**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, TO ENACT THE “SOUTH CAROLINA RIGHT TO SHOP FOR HEALTH CARE ACT” BY ADDING ARTICLE 16 TO CHAPTER 71, TITLE 38 SO AS TO PROVIDE A CITATION; TO PROVIDE NECESSARY DEFINITIONS; TO PROVIDE THAT A HEALTH CARE PROVIDER MUST DISCLOSE THE ALLOWED AMOUNT OF A NONEMERGENCY ADMISSION, PROCEDURE, OR SERVICE WITHIN A CERTAIN TIME FRAME; TO REQUIRE AN INSURANCE CARRIER TO ESTABLISH ACCESS TO AN INTERACTIVE MECHANISM ON ITS PUBLICLY ACCESSIBLE WEBSITE TO ALLOW AN ENROLLEE TO OBTAIN CERTAIN INFORMATION; TO PROVIDE THAT A CARRIER MUST PROVIDE A GOOD FAITH ESTIMATE OF THE ALLOWED AMOUNT AND OUT‑OF‑POCKET COSTS OF A PROPOSED NONEMERGENCY PROCEDURE OR SERVICE UPON REQUEST; TO PROVIDE ALL HEALTH INSURANCE CARRIERS SHALL OFFER SHARED SAVINGS INCENTIVE PROGRAMS AS COMPONENTS OF ALL HEALTH INSURANCE PLANS, SUBJECT TO CERTAIN EXCEPTIONS, TO PROVIDE RELATED REQUIREMENTS CONCERNING THE ESTABLISHMENT OF THESE PROGRAMS, AND THE OFFERING OF INCENTIVES TO HEALTH PLAN ENROLLEES CONCERNING CERTAIN COVERED SHOPPABLE HEALTH CARE SERVICES; TO PROVIDE SHARED SAVINGS INCENTIVE PAYMENTS ARE NOT ADMINISTRATIVE EXPENSES OF THE CARRIER WHO PAID THEM FOR RATE DEVELOPMENT OR RATE FILING PURPOSES; TO PROVIDE WAIVERS FROM THE REQUIREMENTS OF THIS ACT; TO REQUIRE CARRIERS TO ANNUALLY FILE REPORTS OF CERTAIN RELATED INFORMATION TO THE DEPARTMENT; AND TO PROVIDE THE DEPARTMENT MAY ADOPT RULES TO CARRY OUT THE PROVISIONS OF THIS ACT.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Article 16

South Carolina Right to Shop Act

Section 38‑71‑1610. This article must be known and may be cited as the ‘Right to Shop for Health Care Act’.

Section 38‑71‑1615. As used in this article:

(1) ‘Allowed amount’ means the contractually agreed upon amount paid by a carrier to a health care provider participating in the carrier’s network or the amount the health plan is required to pay under the policy or Certificate of Insurance for out‑of‑network covered benefits provided to the patient.

(2) ‘Health care provider’ means a health care professional or facility.

(3) ‘Insurance carrier’ or ‘carrier’ means a health insurance company, health maintenance organization, preferred provider arrangement administrators, fraternal benefit society, nonprofit hospital or medical service organization operating a licensed health plan, self‑insured employer subject to state regulation, and any other entity offering coverage in the State that is subject to the requirements of the Patient Protection and Affordable Care Act, 42 U.S.C. Section 18001, et seq., and that is licensed to do business by the Department of Insurance.

(4) ‘Program’ means a shared savings incentive program established by a carrier pursuant to this section.

(5) ‘Shoppable health care service’ means a health care service for which a carrier offers a shared savings incentive payment under a program established by the carrier pursuant to this section. A shoppable heath care service includes, at a minimum, health care services in the following categories:

(a) physical and occupational therapy services;

(b) obstetrical and gynecological services;

(c) radiology and imaging services;

(d) laboratory services;

(e) infusion therapy;

(f) inpatient and outpatient surgical procedures;

(g) outpatient nonsurgical diagnostic tests or procedures; and

(h) any other service prescribed by the Department of Insurance.

Section 38‑71‑1620. (A) Upon request by a patient or prospective patient and prior to a nonemergency admission, procedure, or service, a health care provider within the patient’s insurer network must, within two working days, disclose the allowed amount of the nonemergency admission, procedure, or service including the amount for any required facility fees.

(B) Upon request by a patient or prospective patient and prior to a nonemergency admission, procedure, or service, a health care provider outside the patient’s insurer network must, within two working days, disclose the amount that will be charged for the nonemergency admission, procedure, or service including the amount for any required facility fees.

(C) If a health care provider is unable to quote a specific amount in advance due to an inability to predict the specific treatment or diagnostic code, the health care provider must disclose what amount is known for the proposed nonemergency admission, procedure, or service, including the amount for any required facility fees. The health care provider must disclose the incomplete nature of the estimate and inform the patient or prospective patient of their ability to obtain an updated estimate once additional information is determined.

(D) If a patient or prospective patient is covered by insurance, a health care provider that participates in a carrier’s network shall, upon request of the patient or prospective patient, provide, based on the information available at the time of the request, sufficient information regarding the proposed nonemergency admission, procedure, or service to provide a cost estimate from the insurance carrier to identify out‑of‑pocket costs. The estimate must be made available to the consumer through a toll‑free telephone number, website, or access to a third‑party service that meets the requirements of this article.

Section 38‑71‑1625. A carrier shall establish access to an interactive mechanism on its publicly accessible website that enables an enrollee to request and obtain information from the carrier or a designated third party on the payments made by the carrier to network providers for health care services. The mechanism must allow an enrollee seeking information about the cost of a particular health care service to compare costs among network providers as established in this article.

Section 38‑71‑1630. (A) Within two days of an enrollee’s request, a carrier shall provide a good faith estimate of the allowed amount and the amount the enrollee will be responsible to pay out‑of‑pocket for a proposed nonemergency procedure or service that is a medically necessary covered benefit from a carrier’s network provider, including any copayment, deductible, coinsurance, or other out‑of‑pocket amount for any covered benefit, based on the information available to the carrier at the time the request is made.

(B) Nothing in this section may prohibit a carrier from imposing cost‑sharing requirements disclosed in the enrollee’s certificate of coverage for unforeseen health care services that arise out of the nonemergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate.

(C) A carrier shall notify an enrollee that the costs provided to the enrollee are estimated costs and the actual amount the enrollee may be responsible to pay may vary due to unforeseen services that arise out of a proposed nonemergency procedure or service.

Section 38‑71‑1635. (A) A carrier shall develop and implement a program that provides incentives for enrollees in a health plan who elect to receive shoppable health care services that are covered by the plan from providers that charge less than the average price paid by that carrier for that shoppable health care service.

(B) An incentive may be calculated as a percentage of the difference in price, as a flat dollar amount, or by some other reasonable methodology approved by the department. The carrier must provide the incentive as a cash payment to the enrollee.

(C) The incentive program must provide enrollees with at least fifty percent of the carrier’s saved costs for each service or category of shoppable health care service resulting from shopping by enrollees. A carrier is not required to provide a payment to an enrollee for when the carrier’s saved cost is fifty dollars or less.

(D) A carrier may determine the methodology for calculating the average price paid by the carrier for a shoppable health care service and the process an enrollee must use to document whether the provider chosen by an enrollee costs less than the average price paid by that carrier. The methodology must be reviewed and approved by the Department of Insurance to ensure compliance with the provisions of this article.

Section 38‑71‑1640. A carrier shall make the program available as a component of all health plans offered by the carrier in this State. Annually at enrollment or renewal, a carrier shall provide notice about the availability of the program to an enrollee who is enrolled in a health plan eligible for the program.

Section 38‑71‑1645. Before a carrier who establishes a program pursuant to this article may offer the program to an enrollee, the carrier shall file a description of the program with the Department of Insurance in the manner determined by the department. The department may review this filing to determine if the carrier’s program complies with the requirements of this article. A filing and supporting documentation made pursuant to this section are confidential until the filing is reviewed.

Section 38‑71‑1650. If an enrollee elects to receive a shoppable health care service from an out‑of‑network provider that results or would otherwise result in a shared savings incentive payment, a carrier shall apply the amount paid for the shoppable health care service toward the enrollee’s member cost sharing as specified in the enrollee’s health plan as if the health care services were provided by a network provider.

Section 38‑71‑1655. A shared savings incentive payment made by a carrier in accordance with this section is not an administrative expense of the carrier for rate development or rate filing purposes.

Section 38‑71‑1660. (A) Beginning March 1, 2019, and annually on March first thereafter, a carrier shall file with the department information from the most recent calendar year concerning the:

(1) total number of shared savings incentive payments made pursuant to this section;

(2) utilization of shoppable health care services by category of service for which shared savings incentives are made;

(3) total payments made to enrollees;

(4) average amount of incentive payments made by service for such transactions;

(5) total savings achieved below the average prices by service for such transactions; and

(6) total number and percentage of a carrier’s enrollees that participated in such transactions.

(B) Beginning April 1, 2020, and annually by April first thereafter, the department shall submit an aggregate report for all carriers filing the information required by this section to the Senate Banking and Insurance Committee and the House of Representatives Labor, Commerce and Industry Committee.

Section 38‑71‑1665. The department may adopt rules as necessary to implement this article.”

SECTION 2. This act takes effect six months after approval by the Governor.

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